SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Filing at a Glance

Company: Time Insurance Company

Product Name: 8079.POL.XX Individual Dental Indemnity Policy - T	SERFF Tr Num: MCHX-G127008137	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 47827
Sub-TOI: H10I.000 Health - Dental	Co Tr Num: 8079.BNS.001.XX	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: SPI McHughConsulting	Disposition Date: 02/07/2011
	Date Submitted: 01/28/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company	Status of Filing in Domicile: Pending
Project Number: 8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 02/07/2011
	State Status Changed: 02/07/2011
Deemer Date:	Created By: SPI McHughConsulting
Submitted By: SPI McHughConsulting	Corresponding Filing Tracking Number:

Filing Description:

Time Insurance Company

NAIC # 69477 FEIN # 39-0658730

Individual Dental Indemnity Benefit Schedule- 8079.BNS.001.XX

Individual Dental Outline of Coverage- 8079.OOC.001.AR

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.
The above-referenced Individual Dental Indemnity forms and rates are hereby submitted for your review seeking approval.

Individual Dental Indemnity Benefit Schedule form 8079.BNS.001.XX replaces form 8079.BNS.XX in its entirety and Individual Dental Outline of Coverage form 8079.OOC.001.AR replaces form 8079.OOC.AR in its entirety. Forms 8079.BNS.XX and 8079.OOC.AR were previously approved by the Department on 01/26/10 via SERFF Filing ID MCHX-126415671.

This filing contains the addition of a benefit waiting period and a benefit reduction provision to both the basic and major dental services benefits. For your ease in review, the differences between the updated/revised form and the form previously approved on 01/26/10 are demarcated in the attached "marked/redlined" edition of the Benefit Schedule.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230-7960 if there are any questions I can answer regarding this filing.

Sincerely,

Tim Hager
Compliance Project Specialist
Mchugh Consulting Resources, Inc.
215-230-7960
mcr@mchughconsulting.com

Attachments

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Company and Contact

Filing Contact Information

Lauren Regnery, Compliance Project Specialist mcr@mchughconsulting.com
McHugh Consulting Resources, Inc. 215-230-7960 [Phone]
2005 South Easton Road, Suite 207 215-230-7961 [FAX]
Doylestown, PA 18901

Filing Company Information

(This filing was made by a third party - McHughConsulting)

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 West Michigan Avenue	Group Code: 19	Company Type:
Milwaukee, WI 53201-0624	Group Name:	State ID Number:
(414) 299-1140 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	$150.00	01/28/2011	44165595

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/07/2011	02/07/2011

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Disposition

Disposition Date: 02/07/2011
Implementation Date:
Status: Approved-Closed
Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Time Insurance Company	0.000%	0.000%	$0	0	$0	0.000%	0.000%

Percent Change Approved:					
Minimum:	%	**Maximum:**	%	**Weighted Average:**	%

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
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Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	01/27/11 Submission Letter	Approved-Closed	Yes
Supporting Document	01/27/11 Rate Submission Letter	Approved-Closed	Yes
Supporting Document	8079.BNS.001.XX Red-Lined Version	Approved-Closed	Yes
Supporting Document	8079.OOC.001.AR Red-Lined Version	Approved-Closed	Yes
Supporting Document	AR Certification of Compliance Rule 19	Approved-Closed	Yes
Supporting Document	Certification Rule 49	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Dental Indemnity Insurance Benefit Schedule	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Actuarial Memorandum/Rates	Approved-Closed	Yes

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Form Schedule

Lead Form Number: 8079.BNS.001.XX

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/07/2011	8079.BNS.001.XX	Schedule Pages	Dental Indemnity Insurance Benefit Schedule	Initial		50.100	8079_BNS_001_XX Dental Sch-Variable-Clean-01_26_11.PDF
Approved-Closed 02/07/2011	8079.OOC.001.AR	Outline of Coverage	Outline of Coverage	Initial		50.100	8079_OOC_001_AR Dental OOC-Variable-Clean-01_26_11.PDF

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

POLICY SCHEDULE
DENTAL INDEMNITY INSURANCE

Policy Number: [ ]
Policyholder: [ ] Effective Date: [ ]
Policyholder Address: [ ]
[Covered Dependent[s]:] [ ] [Effective Date: [ ]]

[INITIAL ANNUAL PREMIUM:][$insert premium]
[PAYMENT OPTION:][Monthly/Quarterly/Semi-Annual/Annual]
[INITIAL [MODE] PREMIUM:][$insert premium]

The benefits listed on this Policy Schedule are for each Covered Person unless otherwise indicated.

[**Benefit Waiting Period:** Benefits under this Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]
[**Basic and Major Services Combined Maximum Benefit Limitation**: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

[Dental Preventive Benefits:	
We will pay one Dental Preventive Benefit of $[50-200], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [$100 - $50,000] per Calendar Year.	
[Procedure Code	**[Dental Preventive Services]**
[00120]	[Periodic oral evaluation]
[00140]	[Limited oral evaluation – problem focused]
[00150]	[Comprehensive Oral Exam – new or established patient]
[00160]	[Detailed and extensive oral evaluation – problem focused, by report]
[00210]	[Intraoral – complete series (including bitewings)]
[00220]	[Intraoral – periapical first film]
[00230]	[Intraoral – periapical each additional film]
[00240]	[Intraoral – occlusal film]
[00250]	[Extraoral – first film]
[00260]	[Extraoral – each additional film]
[00270]	[Bitewing – single film]
[00272]	[Bitewings – two films]
[00274]	[Bitewings – four films]
[00330]	[Panoramic film]
[00340]	[Cephalometric film]
[00415]	[Bacteriologic studies for determination of pathologic agents]
[00460]	[Pulp vitality tests]
[00470]	[Diagnostic casts]

[00471]	[Diagnostic photographs]
[00501]	[Histopathologic Examinations]
[09310]	[Consultation (diagnostic service provided by Dentist or physician other than practitioner)]
[01110]	[Prophylaxis – adult]
[01120]	[Prophylaxis – child]
[01201]	[Topical application of fluoride (including prophylaxis) – child]
[01203]	[Topical application of fluoride (prophylaxis not included) – child]
[01204]	[Topical application of fluoride (prophylaxis not included) – adult]
[01205]	[Topical application of fluoride (including prophylaxis) – adult]
[01351]	[Sealant – per tooth]
[01510]	[Space maintainer – fixed – unilateral]
[01515]	[Space maintainer - fixed – bilateral]
[01520]	[Space maintainer - removable – unilateral]
[01525]	[Space maintainer - removable – bilateral]
[01550]	[Re-cementation of space maintainer]]]

[Basic Dental Services Benefits:

[Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person.]]

[All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]

[Basic Dental Services Benefit Waiting Period: Basic Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the [second] [[180-365] calendar day period][Policy Year] following the [Effective Date][end of the Benefit Waiting Period].]

Procedure Code	**Basic Dental Services**	**Scheduled Benefit**
[09110]	[Palliative (emergency) treatment of dental pain – minor procedure]	[$15-100]
[09220]	[Deep sedation/general anesthesia – first 30 minutes]	[$50-300]
[09221]	[Deep sedation/general anesthesia-each additional 15 minutes]	[$25-150]
[02140]	[Amalgam – one surface, primary or permanent]	[$35-150]
[02150]	[Amalgam – two surfaces – primary or permanent]	[$40-150]
[02160]	[Amalgam – three surfaces – primary or permanent]	[$40-150]
[02161]	[Amalgam – four or more surfaces, primary or permanent]	[$45-200]
[02330]	[Resin-based composite – one surface, anterior]	[$30-150]
[02331]	[Resin-based composite – two surface, anterior]	[$35-150]
[02332]	[Resin-based composite – three surfaces, anterior]	[$40-200]
[02335]	[Resin-based composite – four or more surfaces or involving incisal angle(anterior)]	[$45-200]
[02336]	[Resin-based composite crown (anterior-primary)]	[$45-200]
[02391]	[Resin-based composite – one surface, posterior – permanent or primary]	[$25-150]
[02392]	[Resin-based composite – two surfaces, posterior – permanent or primary]	[$30-150]
[02393]	[Resin-based composite – three surfaces, posterior – permanent or primary]	[$35-200]
[02394]	[Resin-based composite – four or more surfaces, posterior]	[$45-250]
[02410]	[Gold foil – one surface]	[$80-300]
[02420]	[Gold foil – two surfaces]	[$100-400]
[07111]	[Coronal re-cement – deciduous tooth]	[$15-100]
[07140]	[Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]	[$20-100]
[05410]	[Adjust complete denture – maxillary]	[$15-100]
[05411]	[Adjust complete denture – mandibular]	[$15-100]

[05421]	[Adjust partial denture – maxillary]	[$15-100]
[05422]	[Adjust partial denture – mandibular]	[$15-100]
[05510]	[Repair broken complete denture base]	[$50-150]
[05520]	[Replace missing or broken teeth – complete denture (each tooth)]	[$15-100]
[05610]	[Repair resin denture base]	[$20-150]
[05620]	[Repair cast framework]	[$20-200
[05630]	[Repair or replace broken clasp]	[$25-150]
[05640]	[Replace broken teeth – per tooth]	[$15-100]
[05650]	[Add tooth to existing partial denture]	[$30-150]
[05660]	[Add clasp to existing partial denture]	[$25-150]
[05670]	[Replace all teeth and acrylic on case metal framework (maxillary)]	[$60-350]
[05671]	[Replace all teeth and acrylic on case metal framework (mandibular)]	[$60-350]
[05710]	[Rebase complete maxillary denture]	[$60-350]
[05711]	[Rebase complete mandibular denture]	[$60-350]
[05720]	[Rebase maxillary partial denture]	[$60-350]
[05721]	[Rebase mandibular partial denture]	[$60-350]
[05730]	[Reline complete maxillary denture (chairside)]	[$35-200]
[05731]	[Reline complete mandibular denture (chairside)]	[$35-200]
[05740]	[Reline maxillary partial denture (chairside)]	[$35-200]
[05741]	[Reline mandibular partial denture (chairside)]	[$35-200]
[05750]	[Reline complete maxillary denture (laboratory)]	[$50-350]
[05751]	[Reline complete mandibular denture (laboratory)]	[$50-350]
[05760]	[Reline maxillary partial denture (laboratory)]	[$45-350]
[05761]	[Reline mandibular partial denture (laboratory)]	[$45-350]
[05850]	[Tissue conditioning, maxillary]	[$15-100]
[05851]	[Tissue conditioning, mandibular]	[$15-100]
[06930]	[Re-cement fixed partial denture]	[$20-150]]

[Major Dental Services Benefits:

[Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person.]]

[All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]

[Major Dental Services Benefit Waiting Period: Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the [second] [[180

Procedure Code	**[Major Dental Services]**	**Scheduled Benefits**
[02510]	[Inlay – metallic – one surface]	[$155-450]
[02520]	[Inlay – metallic – two surfaces]	[$180-500]
[02530]	[Inlay – metallic – three or more surfaces]	[$210-550]
[02543]	[Onlay – metallic – three surfaces]	[$210-550]
[02544]	[Onlay – metallic – four or more surfaces]	[$210-550]
[02610]	[Inlay – porcelain/ceramic – one surface]	[$180-450]
[02620]	[Inlay – porcelain/ceramic – two surfaces]	[$180-450]
[02630]	[Inlay – porcelain/ceramic – three or more surfaces]	[$210-550]
[02642]	[Onlay – porcelain/ceramic – two surfaces]	[$210-550]
[02643]	[Onlay – porcelain/ceramic – three surfaces]	[$210-550]
[02644]	[Onlay – porcelain/ceramic – four or more surfaces]	[$210-550]

[02650]	[Inlay – resin-based composite – one surface]	[$125-350]
[02651]	[Inlay – resin based composite – two surfaces]	[$130-400]
[02662]	[Onlay – resin based composite – two surfaces]	[$145-400]
[02663]	[Onlay – resin based composite – three surfaces]	[$155-450]
[02910]	[Re-cement inlay]	[$20-150]
[02940]	[Sedative Filling]	[$20-150]
[02951]	[Pin retention – per tooth, in addition to restoration]	[$10-100]
[02710]	[Crown – resin laboratory]	[$80-350]
[02720]	[Crown –resin with high noble metal]	[$180-650]
[02721]	[Crown – resin with predominantly base metal]	[$180-650]
[02722]	[Crown – resin with noble metal]	[$180-650]
[02740]	[Crown – porcelain/ceramic substrate]	[$180-650]
[02750]	[Crown – porcelain fused to high noble metal]	[$180-650]
[02751]	[Crown – porcelain fused to predominantly base metal]	[$180-650]
[02752]	[Crown – porcelain fused to noble metal]	[$180-650]
[02780]	[Crown – ¾ case high noble metal]	[$180-650]
[02781]	[Crown – ¾ case predominantly base metal]	[$180-650]
[02782]	[Crown – ¾ cast noble metal]	[$180-650]
[02790]	[Crown porcelain]	[$180-650]
[02791]	[Crown - full cast predominantly base metal]	[$180-650]
[02792]	[Crown – full cast noble metal]	[$180-650]
[02810]	[Crown – ¾ cast metallic]	[$180-650]
[02920]	[Re-cement crown]	[$20-150]
[02930]	[Prefabricated stainless steel crown – primary tooth]	[$40-200]
[02931]	[Prefabricated stainless steel crown – permanent tooth]	[$50-250]
[02932]	[Prefabricated resin crown]	[$55-250]
[02933]	[Prefabricated stainless steel crown with resin window]	[$60-250]
[02940]	[Sedative filling]	[$20-150]
[02950]	[Core buildup, including any pins]	[$40-200]
[02952]	[Cast post and core in addition to crown]	[$60-250]
[02954]	[Prefabricated post and core in addition to crown]	[$55-250]
[02970]	[Temporary crown (fractured tooth)]	[$35-200]
[03110]	[Pulp cap – direct (excluding final restoration)]	[$10-100]
[03120]	[Pulp cap – indirect (excluding final restoration)]	[$10-100]
[03220]	[Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication]	[$30-150]
[03310]	[Anterior (excluding final restoration)]	[$120-350]
[03320]	[Bicuspid (excluding final restoration)]	[$150-450]
[03330]	[Molar (excluding final restoration)]	[$210-550]
[03346]	[Retreatment of previous root canal therapy – anterior]	[$120-350]
[03347]	[Retreatment of previous root canal therapy – bicuspid]	[$150-400]
[03348]	[Retreatment of previous root canal therapy – molar]	[$240-600]
[03410]	[Apicoectomy/periradicular surgery – anterior]	[$115-300]
[03421]	[Apicoectomy/periradicular surgery – bicuspid (first root)]	[$155-500]
[03425]	[Apicoectomy/periradicular surgery – molar (first root)]	[$205-500]
[03426]	[Apicoectomy/periradicular surgery – (each additional root)]	[$60-250]
[03430]	[Retrograde filling – per root]	[$40-200]
[03450]	[Root amputation – per root]	[$85-350]
[03920]	[Hemisection (including any root removal), not including root canal therapy]	[$65-250]
[00180]	[Comprehensive periodontal evaluation – new or established patient]	[$10-100]
[04210]	[Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$110-300]
[04211]	[Gingivectomy or gingivoplasty – one to three teeth – per quadrant]	[$40-150]
[04240]	[Gingival flap procedure, including root planning – four or more contiguous teeth or	[$150-450]

	bounded teeth spaces per quadrant]	
[04249]	[Clinical crown lengthening – hard tissue]	[$215-450]
[04260]	[Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$205-500]
[04261]	[Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]	[$100-350]
[04263]	[Bone replacement graft – first site in quadrant]	[$60-250]
[04264]	[Bone replacement graft – each additional site in quadrant]	[$30-150]
[04270]	[Pedicle soft tissue graft procedure]	[$150-450]
[04271]	[Free soft tissue graft procedure (including donor site surgery)]	[$150-450]
[04341]	[Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$35-200]
[04355]	[Full mouth debridement to enable comprehensive evaluation and diagnosis]	[$25-150]
[04910]	[Periodontal maintenance]	[$25-150]
[05110]	[Complete denture – maxillary]	[$190-550]
[05120]	[Complete denture – mandibular]	[$190-550]
[05130]	[Immediate denture – maxillary]	[$205-550]
[05140]	[Immediate denture – mandibular]	[$205-550]
[05211]	[Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]	[$155-550]
[05212]	[Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]	[$180-550]
[05213]	[Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]	[$210-550]
[05214]	[Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]	[$210-550]
[05281]	[Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]	[$120-450]
[06210]	[Pontic – cast high noble metal]	[$180-600]
[06211]	[Pontic – cast predominantly base metal]	[$180-600]
[06212]	[Pontic – cast noble metal]	[$180-600]
[06240]	[Pontic – porcelain fused to high noble metal]	[$180-600]
[06241]	[Pontic – porcelain fused to predominantly base metal]	[$180-600]
[06242]	[Pontic – porcelain fused to noble metal]	[$180-600]
[06250]	[Pontic – resin with high noble metal]	[$180-600]
[06251]	[Pontic – resin with predominantly base metal]	[$180-600]
[06252]	[Pontic – with noble metal]	[$180-600]
[06545]	[Retainer – cast metal for resin bonded fixed prosthesis]	[$70-300]
[06602]	[Inlay – cast high noble metal, two surfaces]	[$180-600]
[06603]	[Inlay – cast high noble metal, three or more surfaces]	[$180-600]
[06604]	[Inlay – cast predominantly base metal, two surfaces]	[$180-600]
[06605]	[Inlay – cast predominantly base metal, three or more surfaces]	[$180-600]
[06606]	[Inlay – cast noble metal, two surfaces]	[$180-600]
[06607]	[Inlay – cast noble metal three or more surfaces]	[$180-600]
[06610]	[Onlay – cast high noble metal, two surfaces]	[$180-600]
[06611]	[Onlay – cast high noble metal, three or more surfaces]	[$180-600]
[06612]	[Onlay – cast predominantly base metal, two surfaces]	[$180-600]
[06613]	[Onlay – cast predominantly base metal, three or more surfaces]	[$180-600]
[06614	[Onlay – cast noble metal, two surfaces]	[$180-600]
[06615]	[Onlay – cast noble metal, three or more surfaces]	[$180-600]
[06720]	[Crown – resin with high noble metal]	[$180-600]
[06721]	[Crown – resin with predominantly base metal]	[$180-600]
[06722]	[Crown – resin with noble metal]	[$180-600]
[06740]	[Crown – porcelain/ceramic]	[$180-600]
[06750]	[Crown – porcelain fused to high noble metal]	[$180-600]
[06751]	[Crown – porcelain fused to predominantly base metal]	[$180-600]

[06752]	[Crown – porcelain fused to noble metal]	[$180-600]
[06780]	[Crown – ¾ cast high noble metal]	[$180-600]
[06781]	[Crown – ¾ cast predominantly base metal]	[$180-600]
[06782]	[Crown ¾ cast noble metal]	[$180-600]
[06783]	[Crown ¾ cast porcelain/ceramic]	[$180-600]
[06790]	[Crown – full cast high noble metal]	[$180-600]
[06791]	[Crown – full cast predominantly base metal]	[$180-600]
[06792]	[Crown – full cast noble metal]	[$180-600]
[07210]	[Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]	[$35-200]
[07220]	[Removal of impacted tooth – soft tissue]	[$50-200]
[07230]	[Removal of impacted tooth – partially bony]	[$65-300]
[07240]	[Removal of impacted tooth – completely bony]	[$70-350]
[07241]	[Removal of impacted tooth – completely bony, with unusual surgical complications]	[$95-350]
07250]	[Surgical removal of residual tooth roots (cutting procedure)]	[$40-250]
[07260]	[Oroantral fistula closure]	[$330-1200]
[07270]	[Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]	[$85-350]
[07280]	[Surgical access of unerupted tooth]	[$90-350]
[07281]	[Surgical exposure of impacted or unerupted tooth to aid eruption]	[$65-300]
[07285]	[Biopsy of oral tissue – hard (bone, tooth)]	[$150-500]
[07286]	[Biopsy of oral tissue – soft (all others)]	[$65-300]
[07310]	[Alveoloplasty in conjunction with extractions – per quadrant]	[$40-200]
[07320]	[Alveoloplasty not in conjunction with extractions – per quadrant]	[$170-600]
[07340]	[Vestibuloplasty – ridge extension (secondary epithelialization)]	[$420-1100]
[07350]	[Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)]	[$500-1200]
[07410]	[Excision of benign lesion up to 1.25 cm]	[$65-300]
[07411]	[Excision of benign lesion greater than 1.25 cm]	[$240-750]
[07413]	[Excision of malignant lesion up to 1.25 cm]	[$65-300]
[07414]	[Excision of malignant lesion greater than 1.25 cm]	[$270-800]
[07450]	[Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]	[$65-300]
[07451]	[Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]	[$240-700]
[07460]	[Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]	[$145-500]
[07461]	[Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm]	[$240-750]
[07471]	[Removal of lateral exostosis (maxilla or mandible)]	[$145-500]
[07510]	[Incision and drainage of abscess – intraoral soft tissue]	[$40-200]
[07520]	[Incision and drainage of abscess – extraoral soft tissue]	[$180-650]
[07530]	[Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]	[$65-300]
[07540]	[Removal of reaction producing foreign bodies, musculoskeletal system]	[$80-350]
[07550]	[Partial ostectomy/sequestrectomy for removal of non-vital bone]	[$50-250]
[07560]	[Maxillary sinusotomy for removal of tooth fragment or foreign body]	[$480-1100]
[07960]	[Frenulectomy (frenectomy or frenotomy) - separate procedure]	[$90-350]
[07970]	[Excision of hyperplastic tissue – per arch]	[$90-350]
[07971]	[Excision of pericoronal gingival]	[$30-200]
[07972]	[Surgical reduction of fibrous tuberosity]	[$115-400]
[07980]	[Sialodochoplasty]	[$140-450]]

[Temporomandibular Joint Services Benefits:
[Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]

[Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person].]
[Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.]
[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]

Procedure Code	**Temporomandibular Joint Services**	**Scheduled Benefit**
[00320]	[Temporomandibular joint arthrogram, including injection]	[$130-450]
[07610]	[Maxilla – open reduction (teeth immobilized, if present)]	[$500-600]
[07620]	[Maxilla – closed reduction (teeth immobilized, if present)]	[$485-600]
[07630]	[Mandible - open reduction (teeth immobilized, if present]	[$500-600]
[07640]	[Mandible - closed reduction (teeth immobilized, if present)]	[$500-600]
[07650]	[Malar and/or zygomatic arch – open reduction]	[$400-600]
[07660]	[Malar and/or zygomatic arch – closed reduction]	[$240-600]
[07670]	[Alveolus – closed reduction, may include stabilization of teeth]	[$185-600]
[07671]	[Alveolus – open reduction, may include stabilization of teeth]	[$350-600]
[07710]	[Maxilla – open reduction]	[$500-600]
[07720]	[Maxilla – closed reduction]	[$500-600]
[07730]	[Mandible – open reduction]	[$500-600]
[07740]	[Mandible – closed reduction]	[$500-600]
[07820]	[Closed reduction of dislocation]	[$115-400]
[07870]	[Arthrocentesis]	[$50-200]
[07880]	[Occlusal orthotic device, by report]	[$110-400]]

[**Orthodontic Benefits:**
[Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]
[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] for all Covered Persons combined.]
[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]
[We will pay [actual charges incurred] up to [$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of $[200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.]

Procedure Code	**Orthodontic Dental Services**
[00340]	[Cephalometric film]
[00350]	[Oral/facial images (includes intra and extraoral images)]
[00470]	[Diagnostic casts]
[08030]	[Limited orthodontic treatment of adolescent dentition]
[08080]	[Comprehensive orthodontic treatment of the adolescent dentition]
[08210]	[Removable appliance therapy]

[08220]	[Fixed appliance therapy]
[08660]	[Pre-orthodontic therapy]
[08670]	[Periodic orthodontic treatment visit (as part of contract)]
[08680]	[Orthodontic retention (removal of appliance, construction and placement of retainers)]]

[AGENT INFORMATION]

[Name Address & Telephone Number]

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

DENTAL INDEMNITY INSURANCE
OUTLINE OF COVERAGE FOR
POLICY FORM 8079.POL.AR

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

DENTAL INDEMNITY COVERAGE: Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

DENTAL COVERAGE INFORMATION

[**Benefit Waiting Period:** Benefits under the Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]

[**Basic and Major Services Combined Maximum Benefit Limitation**: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

Dental Preventive Benefits: We will pay one Dental Preventive Benefit of $[xxx], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [$100 - $50,000] per Calendar Year.

[Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [Basic Dental Services Benefit Waiting Period: Basic Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.] [The Scheduled Benefit will be reduced by [xx]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefits shown below will be reduced by [XX]% for any covered procedure rendered during the [second] [[180-365] calendar day period][Policy Year] following the [Effective Date][end of the Benefit Waiting Period].] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $_____.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

[Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [Major Dental Services Benefit Waiting Period: Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.] [The Scheduled Benefit will be reduced by [xx]% for all Major

Dental Services rendered during the first [[180-365] calendar days] [1-2][Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the [second] [[180-365] calendar day period] [Policy Year] following the [Effective Date] [end of the Benefit Waiting Period.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $[_____].] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

[Temporomandibular Joint Services Benefits
We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule [after a Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s]]. [The Scheduled Benefit will be reduced by [xx]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $[_____].] [All benefits for Temporomandibular Joint Services are subject to a maximum lifetime benefit limitation of $[_____] per Covered Person.]]

[Orthodontic Benefits
[The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.] [Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17th] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18th] birthday.] [We will pay benefits for the Orthodontic Dental Services listed on the Policy Schedule when the treatment for Orthodontic Dental Service begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Dental Service if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.] [We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]

[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $[_____] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $[_____] for all Covered Persons combined.]
[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of $[_____] [per Covered Person].]

EXCLUSIONS AND LIMITATIONS:
This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

[We will not pay benefits for any of the following:

1. [any procedure or treatment not shown on the Policy Schedule.]
2. [any procedure rendered during an applicable Benefit Waiting Period.]
3. [any amount in excess of a Calendar Year or lifetime maximum benefit limitation.]
4. [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]
5. [all Experimental or Investigative Services.]
6. [any procedure performed by a person other than a Dentist or Dental Hygienist.]
7. [any procedure performed by a Covered Person's Immediate Family Member.]
8. [all services that are not Dentally Necessary.]
9. [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]
10. [prosthetics replaced less than [xx] years following the previous placement.]
11. [crowns replaced less than [xx] years following the previous placement.]
12. [inlays or onlays replaced less than [XXX] years following the last placement.]
13. [dental implants or the removal of implants.]
14. [Cosmetic Services, unless performed to correct a functional disorder.]
15. [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
16. [replacement of any tooth missing prior to the Effective Date.]
17. [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]
18. [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
19. [any charge or procedure for treatment required because of Dental Injury or disease due to:

    a. [war or any act of war, whether declared or undeclared.]
    b. [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
    c. [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
    d. [taking part in a riot or insurrection, or an act of riot or insurrection.]
    e. [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
    f. [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
    g. [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
    h. [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

20. [procedures rendered before the Effective Date or after the termination date of coverage.]
21. [orthodontic treatment and services.]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:
We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18th] birthday.]

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
5. [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
6. [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
7. [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
8. [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
9. [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65th – 75th] birthday.]

PREMIUM INFORMATION
Premium Payment Mode: _____ INITIAL MODAL PREMIUM AMOUNT: _____ INITIAL ANNUAL PREMIUM AMOUNT: _____

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

Licensed Agent's Signature

Date

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Rate Information

Rate data applies to filing.

Filing Method:	Prior Approval
Rate Change Type:	%
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Time Insurance Company	N/A	0.000%	0.000%	$0	0	$0	0.000%	0.000%

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 02/07/2011	Actuarial Memorandum/Rates	8079.BNS.001.XX	New		Dental Form 8079 Actuarial Memo Revision.PDF

TIME INSURANCE COMPANY

Actuarial Memorandum

Dental Policy Form 8079

A. PURPOSE AND SCOPE

The purpose of this rate filing is to demonstrate the reasonableness of benefits in relationship to premiums, or, if required, more specifically that the anticipated loss ratio of this product meets the minimum requirement. This rate filing is not intended for other purposes.

B. DESCRIPTION

This form provides benefits for covered dental services based on a fixed schedule. The benefit amounts vary by the policy year and are capped at an annual maximum. Three different levels are available for the base plan as well as an optional orthodontic benefit. All three levels cover preventive and diagnostic services, fillings, anesthesia and prosthodontic repairs. Level 3 also covers endodontics, periodontics, other prosthodontic services, prosthetics and oral surgery.

This policy will be issued to individuals between the ages of 0 and 64 and is guaranteed renewable to age 70.

C. BUSINESS PLAN

Dental form 8079 will be sold through agents, brokers and a home office sales force. This policy can be sold standalone or integrated with an Assurant Health medical product.

The application for this form does not contain any underwriting questions based on health status. When a medical product is issued, this policy will be sold on a guarantee issue basis.

D. RATE CALCULATION METHOD

The premiums were calculated on a level issue age basis and by whether the product is sold standalone or integrated with a medical product, the plan level selected and the issue age. The premiums were determined by projecting the expected experience over the lifetime of the policy using the assumptions in section E.

E. ACTUARIAL ASSUMPTIONS

1. Morbidity

Company experience supplemented by Milliman's Dental Cost Guidelines was used to determine the utilization. The company has seen decreased utilization when integrated with a medical product due primarily to the stricter underwriting that medical products require.

2. Policy Termination Rates

The policy termination rates include mortality and were developed off of the company's own experience. Below are sample lapse rates:

Duration	Age 25	Age 35	Age 45	Age 55
1	46.6%	43.3%	39.1%	29.6%
2	46.7%	43.5%	39.5%	30.5%
3	33.6%	31.1%	28.1%	21.5%
4	27.7%	25.6%	23.1%	17.8%
5	24.7%	22.8%	20.6%	15.9%
6	22.9%	21.1%	19.1%	14.8%
7	22.2%	20.4%	18.4%	14.2%
8+	19.6%	18.0%	16.2%	12.4%

3. Expenses

Expenses as a percentage of premiums, reflective of average lifetime levels, are accounted for as follows:

General Expenses	21.0%
Distribution Costs	16.7%
Taxes, Licenses and Fees	2.0%
Total Expenses	39.7%

4. Interest

A level 4.5% annual interest rate is assumed to be earned on the unearned premium reserve and claim reserve. These investment earnings are offsets to required premium.

F. AVERAGE ANNUAL PREMIUM ESTIMATE

The anticipated average annual premium for the proposed rates is $343.

G. PREMIUM MODALIZATION RULES

This policy uses the following modal factors applied to annual premiums:

Mode	Factor
Monthly	0.0875
Quarterly	0.2625
Semi-Annual	0.5250
Annual	1.0000

H. MINIMUM LOSS RATIO

The minimum loss ratio presumed reasonable in NAIC guidelines is 50%.

I. ANTICIPATED LOSS RATIOS

The anticipated lifetime loss ratio for this policy form, calculated as the present value of incurred claims divided by the present value of earned premiums, is 50.6%. Attachment A projects the earned premium and incurred claims by policy year.

J. ACTUARIAL CERTIFICATION

To the best of my knowledge and judgment, this rate filing is in compliance with applicable laws and regulations concerning premium rate development of this state. The benefits are reasonable in relation to the premiums, which are not excessive, inadequate, or unfairly discriminatory.

Brian Seremet, FSA, MAAA
Assistant Actuary
Time Insurance Company

1/21/11
Date

Time Insurance Company
Dental Form 8079 Rates

	Monthly Premiums		
Age Bucket	Level 1	Level 2	Level 3
Per Child	13.2	21.8	28.3
0-17	13.2	21.8	28.3
18-30	15.5	26.5	35.4
31-40	15.5	26.5	42.5
41-50	15.5	26.5	51.0
51-60	15.5	26.5	61.2
61-64	15.5	26.5	67.3

	Adjustment Factors		
Sales Method	Level 1	Level 2	Level 3
Standalone	1.00	1.00	1.00
Integrated	0.60	0.60	0.60

2 Adult Discount Factor		
Level 1	Level 2	Level 3
0.9	0.9	0.9

	Ortho Benefit Monthly Premiums	
Sales Method	Per Adult	Per Child
Standalone	53.0	32.0
Integrated	30.0	18.0

Time Insurance Company
Dental Form 8079

Attachment A
Anticipated Loss Ratio Exhibit

Policy Year	Earned Premium	Incurred Claims	Loss Ratio
1	276,426	108,686	39.3%
2	180,506	92,143	51.0%
3	131,171	78,273	59.7%
4	100,618	56,415	56.1%
5	82,137	45,129	54.9%
6	68,467	37,429	54.7%
7	56,742	30,765	54.2%
8	46,933	25,604	54.6%
9	38,793	21,293	54.9%
10	31,941	17,635	55.2%
11	26,068	14,476	55.5%
12	21,133	11,802	55.8%
13	17,091	9,602	56.2%
14	13,790	7,794	56.5%
15	11,102	6,309	56.8%
16	8,920	5,097	57.1%
17	7,158	4,114	57.5%
18	5,738	3,318	57.8%
19	4,571	2,659	58.2%
20	3,589	2,100	58.5%
21	2,790	1,641	58.8%
22	2,167	1,280	59.1%
23	1,679	996	59.3%
24	1,294	771	59.6%
25	990	592	59.8%
26	756	454	60.1%
27	575	348	60.4%
28	436	265	60.7%
29	330	201	61.1%
30	248	152	61.4%
Lifetime Loss Ratio		50.6%	

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	02/07/2011

Comments:
Form 28565 (10/2009) Application/Enrollment Form for Dental Insurance, approved 12/28/2009.

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	02/07/2011

Comments:
see rates tab

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	02/07/2011

Comments:
see forms tab

		Item Status:	Status Date:
Satisfied - Item:	01/27/11 Submission Letter	Approved-Closed	02/07/2011

Comments:

Attachment:
Submission Letter.PDF

		Item Status:	Status Date:
Satisfied - Item:	01/27/11 Rate Submission Letter	Approved-Closed	02/07/2011

Comments:

Attachment:
Dental Form 8079 Actuarial Memo Cover Letter.PDF

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

		Item Status:	**Status Date:**
Satisfied - Item:	8079.BNS.001.XX Red-Lined Version	Approved-Closed	02/07/2011

Comments:

Attachment:

8079_BNS_001_XX Dental Sch-Variable-redlined-01_26_11.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	8079.OOC.001.AR Red-Lined Version	Approved-Closed	02/07/2011

Comments:

Attachment:

8079_OOC_001_AR Dental OOC-Variable-redlined-01_26_11.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	AR Certification of Compliance Rule 19	Approved-Closed	02/07/2011

Comments:

Attachment:

AR Cert of Compliance with Rule 19.PDF

		Item Status:	**Status Date:**
Satisfied - Item:	Certification Rule 49	Approved-Closed	02/07/2011

Comments:

Attachment:

AR Certificate of Compliance 23-79-138 and R&R 49.PDF

		Item Status:	**Status Date:**

SERFF Tracking Number:	*MCHX-G127008137*	*State:*	*Arkansas*
Filing Company:	*Time Insurance Company*	*State Tracking Number:*	*47827*
Company Tracking Number:	*8079.BNS.001.XX*		
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*8079.POL.XX Individual Dental Indemnity Policy - T*		
Project Name/Number:	*8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company /8079.POL.XX Individual Dental Indemnity Policy - Time Insurance Company*		

Satisfied - Item: Authorization Letter — Approved-Closed — 02/07/2011

Comments:

Attachment:

Assurant Authorization Letter dated 2011.PDF

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability — Approved-Closed — 02/07/2011

Comments:

Attachment:

Individual Dental Variability Statement.PDF

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification — Approved-Closed — 02/07/2011

Comments:

Attachment:

AR Readability Certification.PDF

2005 S. Easton Road, Suite 207
Doylestown, PA 18901
Ph# 215-230-7960
Fax # 215-230-7961
Email:mcr@mchughconsulting.com
www.mchughconsulting.com

McHugh Consulting Resources, Inc.

Sent via SERFF

January 27, 2011

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: Time Insurance Company
NAIC # 69477 FEIN # 39-0658730

Individual Dental Indemnity Benefit Schedule- 8079.BNS.001.XX
Individual Dental Outline of Coverage- 8079.OOC.001.AR

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

The above-referenced Individual Dental Indemnity forms and rates are hereby submitted for your review seeking approval.

Individual Dental Indemnity Benefit Schedule form 8079.BNS.001.XX replaces form 8079.BNS.XX in its entirety and Individual Dental Outline of Coverage form 8079.OOC.001.AR replaces form 8079.OOC.AR in its entirety. Forms 8079.BNS.XX and 8079.OOC.AR were previously approved by the Department on 01/26/10 via SERFF Filing ID MCHX-126415671.

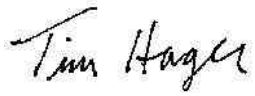
This filing contains the addition of a benefit waiting period and a benefit reduction provision to both the basic and major dental services benefits. For your ease in review, the differences between the updated/revised form and the form previously approved on 01/26/10 are demarcated in the attached “marked/redlined” edition of the Benefit Schedule.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. Some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Attached please find any required certifications and/or transmittal forms and filing fees. Please do not hesitate to contact the undersigned at (215) 230–7960 if there are any questions I can answer regarding this filing.

Sincerely,



Tim Hager
Compliance Project Specialist
Mchugh Consulting Resources, Inc.
215-230-7960
mcr@mchughconsulting.com

Attachments

ASSURANT Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
Phone: 1 800 800 1212

www.assurant.com

January 27, 2011

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

RE: Time Insurance Company
NAIC # 69477 FEIN # 39-0658730

Individual Dental Indemnity Actuarial Memorandum

Dear Commissioner:

Enclosed you will find the actuarial memorandum associated with the revised Dental Indemnity Benefit Schedule submitted for your review seeking approval.

A review of experience has shown that this product has incurred significantly higher early utilization than what was priced for. This increased utilization is concentrated mostly on Major services, which has resulted in higher than expected loss ratios. We are seeking approval on a waiting period on Major services, which will return utilization closer to priced for expectations and enable us to maintain current pricing.

Benefits for Major services are only available on our Level 3 plans. Below is a table of our Level 3 experience when sold on a Standalone basis.

Duration	Current Dental Experience			
Month	Mbr Mo	EP	Loss Ratio	Expected
1	947	38,506	193.3%	75.2%
2	919	37,166	108.8%	55.9%
3	564	22,642	69.1%	43.3%
4	248	10,134	43.7%	35.4%

*This table contains nationwide data as of 1/21/11 and does not adjust for Incurred But Not Reported Claims

Feel free to contact me at the number or e-mail below if you have any questions.

Sincerely,

Brian Seremet, FSA, MAAA
Assistant Actuary
1-800-800-1212 ext. 8272
brian.seremet@assurant.com

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

POLICY SCHEDULE
DENTAL INDEMNITY INSURANCE

Policy Number: [ ]
Policyholder: [ ] Effective Date: [ ]
Policyholder Address: [ ]
[Covered Dependent[s]:] [ ] [Effective Date: [ ]]

[INITIAL ANNUAL PREMIUM:][$insert premium]
[PAYMENT OPTION:][Monthly/Quarterly/Semi-Annual/Annual]
[INITIAL [MODE] PREMIUM:][$insert premium]

The benefits listed on this Policy Schedule are for each Covered Person unless otherwise indicated.

[**Benefit Waiting Period:** Benefits under this Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]
[**Basic and Major Services Combined Maximum Benefit Limitation**: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

[Dental Preventive Benefits:	
We will pay one Dental Preventive Benefit of $[50-200], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [$100 - $50,000] per Calendar Year.	
[Procedure Code	**[Dental Preventive Services]**
[00120]	[Periodic oral evaluation]
[00140]	[Limited oral evaluation – problem focused]
[00150]	[Comprehensive Oral Exam – new or established patient]
[00160]	[Detailed and extensive oral evaluation – problem focused, by report]
[00210]	[Intraoral – complete series (including bitewings)]
[00220]	[Intraoral – periapical first film]
[00230]	[Intraoral – periapical each additional film]
[00240]	[Intraoral – occlusal film]
[00250]	[Extraoral – first film]
[00260]	[Extraoral – each additional film]
[00270]	[Bitewing – single film]
[00272]	[Bitewings – two films]
[00274]	[Bitewings – four films]
[00330]	[Panoramic film]
[00340]	[Cephalometric film]
[00415]	[Bacteriologic studies for determination of pathologic agents]
[00460]	[Pulp vitality tests]
[00470]	[Diagnostic casts]

[00471]	[Diagnostic photographs]
[00501]	[Histopathologic Examinations]
[09310]	[Consultation (diagnostic service provided by Dentist or physician other than practitioner)]
[01110]	[Prophylaxis – adult]
[01120]	[Prophylaxis – child]
[01201]	[Topical application of fluoride (including prophylaxis) – child]
[01203]	[Topical application of fluoride (prophylaxis not included) – child]
[01204]	[Topical application of fluoride (prophylaxis not included) – adult]
[01205]	[Topical application of fluoride (including prophylaxis) – adult]
[01351]	[Sealant – per tooth]
[01510]	[Space maintainer – fixed – unilateral]
[01515]	[Space maintainer - fixed – bilateral]
[01520]	[Space maintainer - removable – unilateral]
[01525]	[Space maintainer - removable – bilateral]
[01550]	[Re-cementation of space maintainer]]]

[Basic Dental Services Benefits:

[Benefits for all covered Basic Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person.]]

[All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]

[Basic Dental Services Benefit Waiting Period: Basic Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar days] [[1-2] Policy Year[s]] following the Effective Date.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the [second] [[180-365] calendar day period][Policy Year] following the [Effective Date][end of the Benefit Waiting Period].]

Procedure Code	**Basic Dental Services**	**Scheduled Benefit**
[09110]	[Palliative (emergency) treatment of dental pain – minor procedure]	[$15-100]
[09220]	[Deep sedation/general anesthesia – first 30 minutes]	[$50-300]
[09221]	[Deep sedation/general anesthesia-each additional 15 minutes]	[$25-150]
[02140]	[Amalgam – one surface, primary or permanent]	[$35-150]
[02150]	[Amalgam – two surfaces – primary or permanent]	[$40-150]
[02160]	[Amalgam – three surfaces – primary or permanent]	[$40-150]
[02161]	[Amalgam – four or more surfaces, primary or permanent]	[$45-200]
[02330]	[Resin-based composite – one surface, anterior]	[$30-150]
[02331]	[Resin-based composite – two surface, anterior]	[$35-150]
[02332]	[Resin-based composite – three surfaces, anterior]	[$40-200]
[02335]	[Resin-based composite – four or more surfaces or involving incisal angle(anterior)]	[$45-200]
[02336]	[Resin-based composite crown (anterior-primary)]	[$45-200]
[02391]	[Resin-based composite – one surface, posterior – permanent or primary]	[$25-150]
[02392]	[Resin-based composite – two surfaces, posterior – permanent or primary]	[$30-150]
[02393]	[Resin-based composite – three surfaces, posterior – permanent or primary]	[$35-200]
[02394]	[Resin-based composite – four or more surfaces, posterior]	[$45-250]
[02410]	[Gold foil – one surface]	[$80-300]
[02420]	[Gold foil – two surfaces]	[$100-400]
[07111]	[Coronal re-cement – deciduous tooth]	[$15-100]
[07140]	[Extraction, erupted tooth or exposed root (elevation and/or forceps removal)]	[$20-100]
[05410]	[Adjust complete denture – maxillary]	[$15-100]
[05411]	[Adjust complete denture – mandibular]	[$15-100]

[05421]	[Adjust partial denture – maxillary]	[$15-100]
[05422]	[Adjust partial denture – mandibular]	[$15-100]
[05510]	[Repair broken complete denture base]	[$50-150]
[05520]	[Replace missing or broken teeth – complete denture (each tooth)]	[$15-100]
[05610]	[Repair resin denture base]	[$20-150]
[05620]	[Repair cast framework]	[$20-200
[05630]	[Repair or replace broken clasp]	[$25-150]
[05640]	[Replace broken teeth – per tooth]	[$15-100]
[05650]	[Add tooth to existing partial denture]	[$30-150]
[05660]	[Add clasp to existing partial denture]	[$25-150]
[05670]	[Replace all teeth and acrylic on case metal framework (maxillary)]	[$60-350]
[05671]	[Replace all teeth and acrylic on case metal framework (mandibular)]	[$60-350]
[05710]	[Rebase complete maxillary denture]	[$60-350]
[05711]	[Rebase complete mandibular denture]	[$60-350]
[05720]	[Rebase maxillary partial denture]	[$60-350]
[05721]	[Rebase mandibular partial denture]	[$60-350]
[05730]	[Reline complete maxillary denture (chairside)]	[$35-200]
[05731]	[Reline complete mandibular denture (chairside)]	[$35-200]
[05740]	[Reline maxillary partial denture (chairside)]	[$35-200]
[05741]	[Reline mandibular partial denture (chairside)]	[$35-200]
[05750]	[Reline complete maxillary denture (laboratory)]	[$50-350]
[05751]	[Reline complete mandibular denture (laboratory)]	[$50-350]
[05760]	[Reline maxillary partial denture (laboratory)]	[$45-350]
[05761]	[Reline mandibular partial denture (laboratory)]	[$45-350]
[05850]	[Tissue conditioning, maxillary]	[$15-100]
[05851]	[Tissue conditioning, mandibular]	[$15-100]
[06930]	[Re-cement fixed partial denture]	[$20-150]]

[Major Dental Services Benefits:
[Benefits for all covered Major Dental Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person.]]
[All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit Limitation shown on this Policy Schedule.]
[Major Dental Services Benefit Waiting Period: Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.]
[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[180-365] calendar day period][[1-2] Policy Year[s]] following the Effective Date.]
[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the [second] [[180

Deleted: [The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the second [[180-365] calendar day period][Policy Year] following the Effective Date.]]

Procedure Code	**[Major Dental Services]**	**Schedul Benefits**
[02510]	[Inlay – metallic – one surface]	[$155-450]
[02520]	[Inlay – metallic – two surfaces]	[$180-500]
[02530]	[Inlay – metallic – three or more surfaces]	[$210-550]
[02543]	[Onlay – metallic – three surfaces]	[$210-550]
[02544]	[Onlay – metallic – four or more surfaces]	[$210-550]
[02610]	[Inlay – porcelain/ceramic – one surface]	[$180-450]
[02620]	[Inlay – porcelain/ceramic – two surfaces]	[$180-450]
[02630]	[Inlay – porcelain/ceramic – three or more surfaces]	[$210-550]
[02642]	[Onlay – porcelain/ceramic – two surfaces]	[$210-550]
[02643]	[Onlay – porcelain/ceramic – three surfaces]	[$210-550]
[02644]	[Onlay – porcelain/ceramic – four or more surfaces]	[$210-550]

[02650]	[Inlay – resin-based composite – one surface]	[$125-350]
[02651]	[Inlay – resin based composite – two surfaces]	[$130-400]
[02662]	[Onlay – resin based composite – two surfaces]	[$145-400]
[02663]	[Onlay – resin based composite – three surfaces]	[$155-450]
[02910]	[Re-cement inlay]	[$20-150]
[02940]	[Sedative Filling]	[$20-150]
[02951]	[Pin retention – per tooth, in addition to restoration]	[$10-100]
[02710]	[Crown – resin laboratory]	[$80-350]
[02720]	[Crown –resin with high noble metal]	[$180-650]
[02721]	[Crown – resin with predominantly base metal]	[$180-650]
[02722]	[Crown – resin with noble metal]	[$180-650]
[02740]	[Crown – porcelain/ceramic substrate]	[$180-650]
[02750]	[Crown – porcelain fused to high noble metal]	[$180-650]
[02751]	[Crown – porcelain fused to predominantly base metal]	[$180-650]
[02752]	[Crown – porcelain fused to noble metal]	[$180-650]
[02780]	[Crown – ¾ case high noble metal]	[$180-650]
[02781]	[Crown – ¾ case predominantly base metal]	[$180-650]
[02782]	[Crown – ¾ cast noble metal]	[$180-650]
[02790]	[Crown porcelain]	[$180-650]
[02791]	[Crown - full cast predominantly base metal]	[$180-650]
[02792]	[Crown – full cast noble metal]	[$180-650]
[02810]	[Crown – ¾ cast metallic]	[$180-650]
[02920]	[Re-cement crown]	[$20-150]
[02930]	[Prefabricated stainless steel crown – primary tooth]	[$40-200]
[02931]	[Prefabricated stainless steel crown – permanent tooth]	[$50-250]
[02932]	[Prefabricated resin crown]	[$55-250]
[02933]	[Prefabricated stainless steel crown with resin window]	[$60-250]
[02940]	[Sedative filling]	[$20-150]
[02950]	[Core buildup, including any pins]	[$40-200]
[02952]	[Cast post and core in addition to crown]	[$60-250]
[02954]	[Prefabricated post and core in addition to crown]	[$55-250]
[02970]	[Temporary crown (fractured tooth)]	[$35-200]
[03110]	[Pulp cap – direct (excluding final restoration)]	[$10-100]
[03120]	[Pulp cap – indirect (excluding final restoration)]	[$10-100]
[03220]	[Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medication]	[$30-150]
[03310]	[Anterior (excluding final restoration)]	[$120-350]
[03320]	[Bicuspid (excluding final restoration)]	[$150-450]
[03330]	[Molar (excluding final restoration)]	[$210-550]
[03346]	[Retreatment of previous root canal therapy – anterior]	[$120-350]
[03347]	[Retreatment of previous root canal therapy – bicuspid]	[$150-400]
[03348]	[Retreatment of previous root canal therapy – molar]	[$240-600]
[03410]	[Apicoectomy/periradicular surgery – anterior]	[$115-300]
[03421]	[Apicoectomy/periradicular surgery – bicuspid (first root)]	[$155-500]
[03425]	[Apicoectomy/periradicular surgery – molar (first root)]	[$205-500]
[03426]	[Apicoectomy/periradicular surgery – (each additional root)]	[$60-250]
[03430]	[Retrograde filling – per root]	[$40-200]
[03450]	[Root amputation – per root]	[$85-350]
[03920]	[Hemisection (including any root removal), not including root canal therapy]	[$65-250]
[00180]	[Comprehensive periodontal evaluation – new or established patient]	[$10-100]
[04210]	[Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$110-300]
[04211]	[Gingivectomy or gingivoplasty – one to three teeth – per quadrant]	[$40-150]
[04240]	[Gingival flap procedure, including root planning – four or more contiguous teeth or	[$150-450]

	bounded teeth spaces per quadrant]	
[04249]	[Clinical crown lengthening – hard tissue]	[$215-450]
[04260]	[Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$205-500]
[04261]	[Osseous surgery (including flap entry and closure) – one to three teeth, per quadrant]	[$100-350]
[04263]	[Bone replacement graft – first site in quadrant]	[$60-250]
[04264]	[Bone replacement graft – each additional site in quadrant]	[$30-150]
[04270]	[Pedicle soft tissue graft procedure]	[$150-450]
[04271]	[Free soft tissue graft procedure (including donor site surgery)]	[$150-450]
[04341]	[Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant]	[$35-200]
[04355]	[Full mouth debridement to enable comprehensive evaluation and diagnosis]	[$25-150]
[04910]	[Periodontal maintenance]	[$25-150]
[05110]	[Complete denture – maxillary]	[$190-550]
[05120]	[Complete denture – mandibular]	[$190-550]
[05130]	[Immediate denture – maxillary]	[$205-550]
[05140]	[Immediate denture – mandibular]	[$205-550]
[05211]	[Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)]	[$155-550]
[05212]	[Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)]	[$180-550]
[05213]	[Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]	[$210-550]
[05214]	[Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)]	[$210-550]
[05281]	[Removable unilateral partial denture – one piece cast metal (including clasps and teeth)]	[$120-450]
[06210]	[Pontic – cast high noble metal]	[$180-600]
[06211]	[Pontic – cast predominantly base metal]	[$180-600]
[06212]	[Pontic – cast noble metal]	[$180-600]
[06240]	[Pontic – porcelain fused to high noble metal]	[$180-600]
[06241]	[Pontic – porcelain fused to predominantly base metal]	[$180-600]
[06242]	[Pontic – porcelain fused to noble metal]	[$180-600]
[06250]	[Pontic – resin with high noble metal]	[$180-600]
[06251]	[Pontic – resin with predominantly base metal]	[$180-600]
[06252]	[Pontic – with noble metal]	[$180-600]
[06545]	[Retainer – cast metal for resin bonded fixed prosthesis]	[$70-300]
[06602]	[Inlay – cast high noble metal, two surfaces]	[$180-600]
[06603]	[Inlay – cast high noble metal, three or more surfaces]	[$180-600]
[06604]	[Inlay – cast predominantly base metal, two surfaces]	[$180-600]
[06605]	[Inlay – cast predominantly base metal, three or more surfaces]	[$180-600]
[06606]	[Inlay – cast noble metal, two surfaces]	[$180-600]
[06607]	[Inlay – cast noble metal three or more surfaces]	[$180-600]
[06610]	[Onlay – cast high noble metal, two surfaces]	[$180-600]
[06611]	[Onlay – cast high noble metal, three or more surfaces]	[$180-600]
[06612]	[Onlay – cast predominantly base metal, two surfaces]	[$180-600]
[06613]	[Onlay – cast predominantly base metal, three or more surfaces]	[$180-600]
[06614	[Onlay – cast noble metal, two surfaces]	[$180-600]
[06615]	[Onlay – cast noble metal, three or more surfaces]	[$180-600]
[06720]	[Crown – resin with high noble metal]	[$180-600]
[06721]	[Crown – resin with predominantly base metal]	[$180-600]
[06722]	[Crown – resin with noble metal]	[$180-600]
[06740]	[Crown – porcelain/ceramic]	[$180-600]
[06750]	[Crown – porcelain fused to high noble metal]	[$180-600]
[06751]	[Crown – porcelain fused to predominantly base metal]	[$180-600]

[06752]	[Crown – porcelain fused to noble metal]	[$180-600]
[06780]	[Crown – ¾ cast high noble metal]	[$180-600]
[06781]	[Crown – ¾ cast predominantly base metal]	[$180-600]
[06782]	[Crown ¾ cast noble metal]	[$180-600]
[06783]	[Crown ¾ cast porcelain/ceramic]	[$180-600]
[06790]	[Crown – full cast high noble metal]	[$180-600]
[06791]	[Crown – full cast predominantly base metal]	[$180-600]
[06792]	[Crown – full cast noble metal]	[$180-600]
[07210]	[Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth]	[$35-200]
[07220]	[Removal of impacted tooth – soft tissue]	[$50-200]
[07230]	[Removal of impacted tooth – partially bony]	[$65-300]
[07240]	[Removal of impacted tooth – completely bony]	[$70-350]
[07241]	[Removal of impacted tooth – completely bony, with unusual surgical complications]	[$95-350]
07250]	[Surgical removal of residual tooth roots (cutting procedure)]	[$40-250]
[07260]	[Oroantral fistula closure]	[$330-1200]
[07270]	[Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth]	[$85-350]
[07280]	[Surgical access of unerupted tooth]	[$90-350]
[07281]	[Surgical exposure of impacted or unerupted tooth to aid eruption]	[$65-300]
[07285]	[Biopsy of oral tissue – hard (bone, tooth)]	[$150-500]
[07286]	[Biopsy of oral tissue – soft (all others)]	[$65-300]
[07310]	[Alveoloplasty in conjunction with extractions – per quadrant]	[$40-200]
[07320]	[Alveoloplasty not in conjunction with extractions – per quadrant]	[$170-600]
[07340]	[Vestibuloplasty – ridge extension (secondary epithelialization)]	[$420-1100]
[07350]	[Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachments and management of hypertrophied tissue)]	[$500-1200]
[07410]	[Excision of benign lesion up to 1.25 cm]	[$65-300]
[07411]	[Excision of benign lesion greater than 1.25 cm]	[$240-750]
[07413]	[Excision of malignant lesion up to 1.25 cm]	[$65-300]
[07414]	[Excision of malignant lesion greater than 1.25 cm]	[$270-800]
[07450]	[Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm.]	[$65-300]
[07451]	[Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm]	[$240-700]
[07460]	[Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm]	[$145-500]
[07461]	[Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm]	[$240-750]
[07471]	[Removal of lateral exostosis (maxilla or mandible)]	[$145-500]
[07510]	[Incision and drainage of abscess – intraoral soft tissue]	[$40-200]
[07520]	[Incision and drainage of abscess – extraoral soft tissue]	[$180-650]
[07530]	[Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue]	[$65-300]
[07540]	[Removal of reaction producing foreign bodies, musculoskeletal system]	[$80-350]
[07550]	[Partial ostectomy/sequestrectomy for removal of non-vital bone]	[$50-250]
[07560]	[Maxillary sinusotomy for removal of tooth fragment or foreign body]	[$480-1100]
[07960]	[Frenulectomy (frenectomy or frenotomy) - separate procedure]	[$90-350]
[07970]	[Excision of hyperplastic tissue – per arch]	[$90-350]
[07971]	[Excision of pericoronal gingival]	[$30-200]
[07972]	[Surgical reduction of fibrous tuberosity]	[$115-400]
[07980]	[Sialodochoplasty]	[$140-450]]

[Temporomandibular Joint Services Benefits:
[Temporomandibular Joint Services Benefit Waiting Period: Temporomandibular Joint Services Benefits under this Policy are only payable for covered procedures rendered after[[180-365] calendar days] [1-3] Policy Year[s] from the Effective Date.]

[Benefits for all covered Temporomandibular Joint Services rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person].]

[Benefits for all covered Temporomandibular Joint Services are limited to a maximum lifetime benefit of [$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Temporomandibular Joint Services Benefits are available [for that Covered Person] under this Policy.]

[The Scheduled Benefits shown below will be reduced by [5-100]% for any covered procedure rendered during the first [[1-3]Policy Year[s]] following the [Effective Date][end of the Benefit Waiting Period].]

Procedure Code	**Temporomandibular Joint Services**	**Scheduled Benefit**
[00320]	[Temporomandibular joint arthrogram, including injection]	[$130-450]
[07610]	[Maxilla – open reduction (teeth immobilized, if present)]	[$500-600]
[07620]	[Maxilla – closed reduction (teeth immobilized, if present)]	[$485-600]
[07630]	[Mandible - open reduction (teeth immobilized, if present]	[$500-600]
[07640]	[Mandible - closed reduction (teeth immobilized, if present)]	[$500-600]
[07650]	[Malar and/or zygomatic arch – open reduction]	[$400-600]
[07660]	[Malar and/or zygomatic arch – closed reduction]	[$240-600]
[07670]	[Alveolus – closed reduction, may include stabilization of teeth]	[$185-600]
[07671]	[Alveolus – open reduction, may include stabilization of teeth]	[$350-600]
[07710]	[Maxilla – open reduction]	[$500-600]
[07720]	[Maxilla – closed reduction]	[$500-600]
[07730]	[Mandible – open reduction]	[$500-600]
[07740]	[Mandible – closed reduction]	[$500-600]
[07820]	[Closed reduction of dislocation]	[$115-400]
[07870]	[Arthrocentesis]	[$50-200]
[07880]	[Occlusal orthotic device, by report]	[$110-400]]

[**Orthodontic Benefits:**

[Orthodontic Benefits are payable only after satisfaction of the Orthodontic Dental Services Benefit Waiting Period. The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.]

[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of [$100-50,000] for all Covered Persons combined.]

[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of [$100-50,000] [per Covered Person]. Once this maximum has been met, no additional Orthodontic Benefits are available [for that Covered Person] under this policy.]

[We will pay [actual charges incurred] up to [$200-600] for the initial Orthodontic Treatment consisting of one or more of the Orthodontic Dental Services listed below. Thereafter a fixed indemnity benefit of $[200-600] is payable once [every three months] [every month] for continued Orthodontic Treatment involving one or more of the Orthodontic Dental Services listed below.]

Procedure Code	**Orthodontic Dental Services**
[00340]	[Cephalometric film]
[00350]	[Oral/facial images (includes intra and extraoral images)]
[00470]	[Diagnostic casts]
[08030]	[Limited orthodontic treatment of adolescent dentition]
[08080]	[Comprehensive orthodontic treatment of the adolescent dentition]
[08210]	[Removable appliance therapy]

[08220]	[Fixed appliance therapy]
[08660]	[Pre-orthodontic therapy]
[08670]	[Periodic orthodontic treatment visit (as part of contract)]
[08680]	[Orthodontic retention (removal of appliance, construction and placement of retainers)]]

[AGENT INFORMATION]

[Name Address & Telephone Number]

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

DENTAL INDEMNITY INSURANCE
OUTLINE OF COVERAGE FOR
POLICY FORM 8079.POL.AR

THE POLICY PROVIDES LIMITED BENEFITS

THE POLICY PROVIDES COVERAGE FOR DENTAL BENEFITS ONLY AND DOES NOT PROVIDE REIMBURSEMENT OF MEDICAL EXPENSES

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of the Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both You and Time Insurance Company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

DENTAL INDEMNITY COVERAGE: Policies of this category are designed to provide, to the person insured, benefits when specified dental procedures are rendered, subject to any limitations set forth in the Policy and in the amount shown on the Policy Schedule. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

DENTAL COVERAGE INFORMATION

[**Benefit Waiting Period:** Benefits under the Policy[, except Dental Preventive Benefits,] are payable after [30-180] calendar days from the Effective Date [unless as otherwise specified].]

[**Basic and Major Services Combined Maximum Benefit Limitation**: Benefits for all covered Basic Dental Services and Major Dental Services combined are limited to a maximum Calendar Year benefit of [$100-50,000] [per Covered Person]. This benefit limitation is in addition to any other maximum benefit limitation specified below.]

Dental Preventive Benefits: We will pay one Dental Preventive Benefit of $[xxx], regardless of the number of visits to a Dentist or Dental Hygienist or the number of services received, every [90-270] calendar days. Dental Preventive Benefits are limited to a maximum benefit of [$100 - $50,000] per Calendar Year.

[Basic Dental Services Benefits: We will pay the Scheduled Benefit for Basic Dental Services as show on the Policy Schedule. [Basic Dental Services Benefit Waiting Period: Basic Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.] [The Scheduled Benefit will be reduced by [xx]% for all Basic Dental Services rendered during the first [[180-365] calendar days] [1-2] [Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefits shown below will be reduced by [XX]% for any covered procedure rendered during the [second] [[180-365] calendar day period][Policy Year] following the [Effective Date][end of the Benefit Waiting Period].] [All benefits for Basic Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $_____.] [All benefits for covered Basic Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

[Major Dental Services Benefits: We will pay the Scheduled Benefit for Major Dental Services as show on the Policy Schedule. [Major Dental Services Benefit Waiting Period: Major Dental Services Benefits under this Policy are only payable for covered procedures rendered after [[30-365] calendar days] [[1-3] Policy Year[s]] from the Effective Date.] [The Scheduled Benefit will be reduced by [xx]% for all Major

Dental Services rendered during the first [[180-365] calendar days] [1-2][Policy Year][s] following the Effective Date of coverage.] [The Scheduled Benefit will be reduced by [xx]% for all Major Dental Services rendered during the [second] [[180-365] calendar day period] [Policy Year] following the [Effective Date] [end of the Benefit Waiting Period.] [All benefits for Major Dental Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $[_____].] [All benefits for covered Major Dental Services are subject to the Basic and Major Services Combined Maximum Benefit.]]

Deleted: days

Deleted: [1-2]

Deleted: [s]

Deleted: coverage

[Temporomandibular Joint Services Benefits
We will pay the Scheduled Benefit for Temporomandibular Joint Services as show on the Policy Schedule [after a Benefit Waiting Period of [[180-365] calendar days] [1-3] [Policy Year][s]]. [The Scheduled Benefit will be reduced by [xx]% for all Temporomandibular Joint Services rendered during the first [1-3] [Policy Year][s] following the [Effective Date of coverage][end of the Benefit Waiting Period].] [Thereafter the full Scheduled Benefit will be paid for covered Temporomandibular Joint Services.] [All benefits for Temporomandibular Joint Services rendered during the same Calendar Year are subject to a maximum Calendar Year benefit limitation of $[_____].] [All benefits for Temporomandibular Joint Services are subject to a maximum lifetime benefit limitation of $[_____] per Covered Person.]]

[Orthodontic Benefits
[The Orthodontic Dental Services Benefit Waiting Period is [1-3] Policy Year[s] following the Effective Date of coverage.] [Only Covered Persons who are under age [18] years are eligible for Orthodontic Benefits. Orthodontic Treatment must have been initiated prior to the Covered Person's [17th] birthday. Benefits for Orthodontic Treatment cease upon attainment of the Covered Person's [18th] birthday.] [We will pay benefits for the Orthodontic Dental Services listed on the Policy Schedule when the treatment for Orthodontic Dental Service begins while the Covered Person is insured under the plan. No payment will be made for the Orthodontic Dental Service if the appliances or bands are inserted prior to becoming insured. We consider Orthodontic Treatment to be started on the date the bands or appliances are inserted. Any other Orthodontic Treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the Orthodontic Treatment is rendered.] [We will make a payment for covered orthodontic services related to the initial Orthodontic Treatment, which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial Orthodontic Treatment, benefits for covered Orthodontic Dental Services will be paid in equal [monthly] [quarterly] payments over the course of the remaining Orthodontic Treatment. The initial Orthodontic Treatment and [quarterly] [monthly] indemnity benefit amounts are shown on the Policy Schedule.]

[Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $[_____] per Covered Person.] [Benefits for all covered Orthodontic Treatment rendered during the same Calendar Year are limited to a maximum Calendar Year benefit of $[_____] for all Covered Persons combined.]
[Benefits for all covered Orthodontic Treatment are limited to a maximum lifetime benefit of $[_____] [per Covered Person].]

EXCLUSIONS AND LIMITATIONS:
This Policy pays limited, fixed indemnity benefits for Dental Treatments only. See the Policy Schedule for the limited benefit amounts and maximum benefit limitations.

[We will not pay benefits for any of the following:

1. [any procedure or treatment not shown on the Policy Schedule.]
2. [any procedure rendered during an applicable Benefit Waiting Period.]
3. [any amount in excess of a Calendar Year or lifetime maximum benefit limitation.]
4. [Dental Preventive Benefits when there is less than [90-270] calendar days between the dates of service for Dental Preventive Services.]
5. [all Experimental or Investigative Services.]
6. [any procedure performed by a person other than a Dentist or Dental Hygienist.]
7. [any procedure performed by a Covered Person's Immediate Family Member.]
8. [all services that are not Dentally Necessary.]
9. [repairs to dental work less than [30-180] calendar days following completion of the initial procedure.]
10. [prosthetics replaced less than [xx] years following the previous placement.]
11. [crowns replaced less than [xx] years following the previous placement.]
12. [inlays or onlays replaced less than [XXX] years following the last placement.]
13. [dental implants or the removal of implants.]
14. [Cosmetic Services, unless performed to correct a functional disorder.]
15. [services performed outside the United States [and][,] [its territories] [and Canada] except for services that are received for Emergency Dental Treatment.]
16. [replacement of any tooth missing prior to the Effective Date.]
17. [placement of full or partial dentures, whether removable or fixed, including a Maryland Bridge, unless replacing a Functioning Natural Tooth extracted after the Effective Date[and not within a Benefit Waiting Period].]
18. [for Covered Persons under age 16, inlays, onlays, bridgework or crowns except for stainless steel or plastic crowns.]
19. [any charge or procedure for treatment required because of Dental Injury or disease due to:

    a. [war or any act of war, whether declared or undeclared.]
    b. [participation in the military service of any country or international organization[,including non-military units supporting such forces.]]
    c. [charges for Sickness or Injury caused or aggravated by attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
    d. [taking part in a riot or insurrection, or an act of riot or insurrection.]
    e. [participating in, voluntarily attempting to commit or commission of a felony, whether or not charged, or engaging in an illegal occupation or activity at the time of an Accident.]
    f. [voluntary use of any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's health care practitioner.]
    g. [riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot.]
    h. [charges for treatment or services required due to an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, was [.08] or higher. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

20. [procedures rendered before the Effective Date or after the termination date of coverage.]
21. [orthodontic treatment and services.]

[In addition to the Exclusions listed above, the following exclusion applies to Orthodontic Dental Services coverage:
We will not pay benefits for Orthodontic Treatment procedures rendered after the Covered Person's [18th] birthday.]

RENEWABILITY PROVISION: The policy is guaranteed renewable until 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. the date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. the date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
3. the date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. [the date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person [applying for this coverage or] filing a claim for benefits.]
5. [the date all policies with the same form number as this Policy are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.]
6. [the date We terminate or non-renew [health][dental] insurance coverage in the individual market in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.]
7. [[on][t]he date the Policyholder moves to a state where We do not provide insurance coverage under the same plan as this Policy[, We reserve the right to terminate this coverage].]
8. [for a Covered Dependent: on the date a Covered Dependent no longer meets the Dependent definition in this plan.]
9. [the date the Policyholder attains age [65-75] years.] [The anniversary date of this Policy following the Policyholder's [65th – 75th] birthday.]

PREMIUM INFORMATION
Premium Payment Mode: _____ INITIAL MODAL PREMIUM AMOUNT: _____ INITIAL ANNUAL PREMIUM AMOUNT: _____

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your geographic area, [gender,] [age,] payment method and plan design. All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You add or delete Covered Dependents, change the payment method, move to another zip code or otherwise change the coverage.

Licensed Agent's Signature

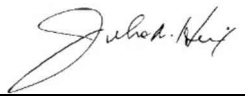
Date

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s): 8079.BNS.001.XX, 8079.OOC.001.AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Julia Hix

Name

Vice President, Product Compliance

Title

January 27, 2011

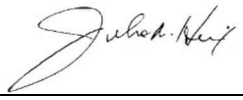
Date

CERTIFICATE OF COMPLIANCE

Insurer: Time Insurance Company

Form Numbers:
8079.BNS.001.XX, 8079.OOC.001.AR

I hereby certify that the filing above meets all applicable Arkansas requirements including Regulation 49 (Life and Health Guaranty Fund Notice) and Ark. Code Ann. 23-79-138 and Bulletin 11-88 (Consumer Information Notice).



Signature of Company Officer

Julia Hix
Name

Vice President-Product Compliance
Title

January 27, 2011
Date

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

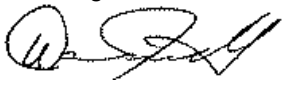
January 2011

Re: Time Insurance Company-NAIC 69477; FEIN 39-0658730

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file any or all policy forms on behalf of the above referenced company and to serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,



Daniel Ziebell, MHP
Director Product Compliance
Worksite, Voluntary and Ancillary Products
daniel.ziebell@assurant.com
T 414.299.6045
F 414.299.6168

Statement of Variability

- All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

- Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

- Definitions may vary to the extent that such definition may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

- Items which customarily vary according to the policyholder's specific plan of insurance.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval and amend the language to clarify the intent within the confines of the law.

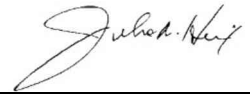
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Time Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
8079.BNS.001.XX	50.1
8079.OOC.001.AR	50.1

Signed: 

Name: Julia Hix

Title: Vice President, Product Compliance

Date: January 27, 2011